



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

MMC OF EAST TEXAS
201 LAKE WOODLANDS DR SUITE 4024
THE WOODLANDS, TEXAS 77380

Respondent Name

New Hampshire Insurance Co

Carrier's Austin Representative Box

Box Number 19

MFDR Tracking Number

M4-13-0395-01

MFDR Date Received

October 5, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "... Chartis has made no effort at substantiating this denial; we maintain that your company is presently in direct conflict with TEX. LAB. CODE §415.002 (a)(11) for failing to process this medical bill in a "reasonable and prudent manner."

Amount in Dispute: \$42,524.30

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The bill reflects a total of 98 hours observation time. This should have been billed as an inpatient stay with an appropriate DRG."

Response Submitted by: Chartis, 4100 Alpha Road, Suite 700, Dallas, Texas, 75244

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
December 5 – 9, 2011	Outpatient Hospital Services	\$42,524.30	\$4,916.06

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403, titled *Hospital Facility Fee Guideline – Outpatient*, sets out the reimbursement guidelines for facility services provided in an outpatient acute care hospital.
3. 28 Texas Administrative Code §134.203, titled *Medical Fee Guideline for Professional Services*, sets out the reimbursement guidelines for professional medical services.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

- 45 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.
- Documentation shows hospital stay exceeds 23 hours.

Issues

1. Did the respondent support the insurance carrier's reasons for reduction or denial of services?
2. Are the disputed services subject to a contractual agreement between the parties to this dispute?
3. What is the applicable rule for determining reimbursement for the disputed services?
4. What is the recommended payment amount for the services in dispute?
5. Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Administrative Code §134.203(b)(1), in pertinent part, "for coding, billing, reporting and reimbursement of professional medical services. Texas Workers' Compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; ...and other payment policies in effect on the date a service is provided..." Carrier denied medical billing using reason, "Documentation shows hospital stay exceeds 23 hours. Medicare Claims Processing Manual, Chapter 4 - Part B Hospital (Including Inpatient Hospital Part B and OPPTS), Chapter 290.1 – Observation Services Overview states, "Observation services must also be reasonable and necessary to be covered by Medicare. In only rare and exceptional cases do reasonable and necessary outpatient observation services span more than 48 hours. In the majority of cases, the decision whether to discharge a patient from the hospital following resolution of the reason for the observation care or to admit the patient as an inpatient can be made in less than 48 hours, usually in less than 24 hours." As this Medicare payment policy does not restrict observation time, the services in dispute will be reviewed pursuant to the applicable division fee guidelines.
2. Review of the submitted documentation finds no information to support that the disputed services are subject to a contractual agreement between the parties to this dispute, nor can the division establish what type of contract – Informal or Voluntary pursuant to Texas Labor Code §413.011 (d-1) through (d-3) regarding informal and voluntary networks for the type of service in this dispute expired on December 31, 2010. The division concludes that reduction code 45 is not supported, for that reason; the services in dispute will be reviewed pursuant to the applicable division fee guidelines.
3. This dispute relates to facility services performed in an outpatient hospital setting with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register with the application of minimal modifications as set forth in the rule. Per §134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables. Review of the submitted documentation finds that separate reimbursement for implantables is not applicable.
4. Under the Medicare Outpatient Prospective Payment System (OPPS), each billed service is assigned an Ambulatory Payment Classification (APC) based on the procedure code used, the supporting documentation and the other services that appear on the bill. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Payment for ancillary and supportive items and services, including services that are billed without procedure codes, is packaged into payment for the primary service. A full list of APCs is published quarterly in the OPPS final rules which are publicly available through the Centers for Medicare and Medicaid Services (CMS) website. Reimbursement for the disputed services is calculated as follows:
 - Per Medicare policy, procedure code 96374, date of service December 5, 2011 may not be reported with procedure code 99285 billed on the same claim. Payment for this service is included in the payment for the primary procedure. Separate payment is not recommended.
 - Procedure code 96375, date of service December 5, 2011, has a status indicator of S, which denotes a significant procedure, not subject to multiple-procedure discounting, paid under OPPS with separate APC payment. These services are classified under APC 0437, which, per OPPS Addendum A, has a payment rate of \$36.88. This amount multiplied by 60% yields an unadjusted labor-related amount of \$22.13. This amount multiplied by the annual wage index for this facility of 0.8689 yields an adjusted labor-related amount of \$19.23. The non-labor related portion is 40% of the APC rate or \$14.75. The sum of the labor and non-labor related amounts is \$33.98 multiplied by 3 units is \$101.94. The cost of these services does not exceed the annual fixed-dollar threshold of \$2,025. The outlier payment amount is \$0. The total Medicare facility specific reimbursement amount for this line is \$101.94. This amount multiplied by 200% yields a MAR of

\$203.88.

- Procedure code 96376, date of service December 5, 2011, is an add-on code that represents services performed subsequent to another initial service. Per Medicare policy, this code is not eligible for payment unless reported with an appropriate primary procedure. Review of the submitted documentation finds that an appropriate primary procedure was not reported. Reimbursement is not recommended.
- Procedure code 96376, date of service December 6, 2011, has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code 96375, date of service December 7, 2011, is an add-on code that represents services performed subsequent to another initial service. Per Medicare policy, this code is not eligible for payment unless reported with an appropriate primary procedure. Review of the submitted documentation finds that an appropriate primary procedure was not reported. Reimbursement is not recommended.
- Procedure code 96376, date of service December 7, 2011, is an add-on code that represents services performed subsequent to another initial service. Per Medicare policy, this code is not eligible for payment unless reported with an appropriate primary procedure. Review of the submitted documentation finds that an appropriate primary procedure was not reported. Reimbursement is not recommended.
- Procedure code 96376, date of service December 8, 2011, is an add-on code that represents services performed subsequent to another initial service. Per Medicare policy, this code is not eligible for payment unless reported with an appropriate primary procedure. Review of the submitted documentation finds that an appropriate primary procedure was not reported. Reimbursement is not recommended.
- Procedure code 96376, date of service December 9, 2011, is an add-on code that represents services performed subsequent to another initial service. Per Medicare policy, this code is not eligible for payment unless reported with an appropriate primary procedure. Review of the submitted documentation finds that an appropriate primary procedure was not reported. Reimbursement is not recommended.
- Procedure code 36415, date of service December 5, 2011, has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is \$3.00. 125% of this amount is \$3.75
- Procedure code 80048, date of service December 5, 2011, has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is \$11.91. 125% of this amount is \$14.89
- Procedure code 81001, date of service December 5, 2011, has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is \$4.45. 125% of this amount is \$5.56
- Procedure code 85025, date of service December 5, 2011, has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is \$10.94. 125% of this amount is \$13.67
- Procedure code 87040, date of service December 5, 2011, has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is \$14.53. This amount multiplied by 2 units is \$29.06. 125% of this amount

is \$36.32

- Procedure code 36415, date of service December 6, 2011, has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is \$3.00. 125% of this amount is \$3.75
- Procedure code 82306, date of service December 6, 2011, has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is \$38.24. 125% of this amount is \$47.80
- Procedure code 82607, date of service December 6, 2011, has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is \$21.21. 125% of this amount is \$26.51
- Procedure code 82746, date of service December 6, 2011, has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is \$20.69. 125% of this amount is \$25.86
- Procedure code 83036, date of service December 6, 2011, has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is \$13.66. 125% of this amount is \$17.07
- Procedure code 85651, date of service December 6, 2011, has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is \$5.00. 125% of this amount is \$6.25
- Procedure code 86038, date of service December 6, 2011, has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is \$17.01. 125% of this amount is \$21.26
- Procedure code 36415, date of service December 7, 2011, has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is \$3.00. 125% of this amount is \$3.75
- Procedure code 84443, date of service December 7, 2011, has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS,

reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is \$23.64. 125% of this amount is \$29.55

- Procedure code 85613, date of service December 7, 2011, has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is \$9.84. 125% of this amount is \$12.30
- Procedure code 85651, date of service December 7, 2011, has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is \$5.00. 125% of this amount is \$6.25
- Procedure code 85705, date of service December 7, 2011, has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is \$11.96. 125% of this amount is \$14.95
- Procedure code 85730, date of service December 7, 2011, has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is \$8.45. 125% of this amount is \$10.56
- Procedure code 86038, date of service December 7, 2011, has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is \$17.01. 125% of this amount is \$21.26
- Procedure code 99285, date of service December 5, 2011, has a status indicator of Q3, which denotes conditionally packaged codes that may be paid through a composite APC if OPPS criteria are met; however, review of the submitted information finds that the criteria for composite payment have not been met. Therefore, this line may be paid separately. These services are classified under APC 0616, which, per OPPS Addendum A, has a payment rate of \$329.54. This amount multiplied by 60% yields an unadjusted labor-related amount of \$197.72. This amount multiplied by the annual wage index for this facility of 0.8689 yields an adjusted labor-related amount of \$171.80. The non-labor related portion is 40% of the APC rate or \$131.82. The sum of the labor and non-labor related amounts is \$303.62. The cost of these services does not exceed the annual fixed-dollar threshold of \$2,025. The outlier payment amount is \$0. The total Medicare facility specific reimbursement amount for this line is \$303.62. This amount multiplied by 200% yields a MAR of \$607.24.
- Procedure code 72157, date of service December 6, 2011, has a status indicator of Q3, which denotes conditionally packaged codes that may be paid through a composite APC. If OPPS criteria are met, this service is assigned to composite APC 8008. This service meets the criteria for composite payment. A service that is assigned to a composite APC is a major component of a single episode of care. The hospital receives one payment through a composite APC for multiple major separately identifiable services. Payment for any combination of designated procedures performed on the same date is packaged into a single payment. If a claim includes a composite payment that pays for more than one otherwise separately paid service, the charges for all services included in the composite are summed up to one line. To determine outlier payments, a single cost for the composite APC is estimated from the summarized charges. Total packaged cost is allocated to the composite line-item in proportion to other separately paid services on the claim. The payment for composite services is calculated below.

- Procedure code 72158, date of service December 6, 2011, has a status indicator of Q3, which denotes conditionally packaged codes that may be paid through a composite APC. If OPPS criteria are met, this service is assigned to composite APC 8008. This service meets the criteria for composite payment. A service that is assigned to a composite APC is a major component of a single episode of care. The hospital receives one payment through a composite APC for multiple major separately identifiable services. Payment for any combination of designated procedures performed on the same date is packaged into a single payment. If a claim includes a composite payment that pays for more than one otherwise separately paid service, the charges for all services included in the composite are summed up to one line. To determine outlier payments, a single cost for the composite APC is estimated from the summarized charges. Total packaged cost is allocated to the composite line-item in proportion to other separately paid services on the claim. The payment for composite services is calculated below.
- Procedure code J1170 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J2270 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J2405 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J2543 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J3370 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code A9579, date of service December 6, 2011, has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J1652, date of service December 6, 2011, has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J2270, date of service December 6, 2011, has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J2543, date of service December 6, 2011, has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J1652, date of service December 7, 2011, has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J2270, date of service December 7, 2011, has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J2543, date of service December 7, 2011, has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J1652, date of service December 8, 2011, has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J2270, date of service December 8, 2011, has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J2543, date of service December 8, 2011, has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J2270, date of service December 9, 2011, has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J2543, date of service December 9, 2011, has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.

- Per Medicare policy, procedure code 96372, date of service December 6, 2011, may not be reported with procedure code 72157 billed on the same claim. Payment for this service is included in the payment for the primary procedure. Separate payment is not recommended.
- Procedure code 96372, date of service December 7, 2011, has a status indicator of S, which denotes a significant procedure, not subject to multiple-procedure discounting, paid under OPSS with separate APC payment. These services are classified under APC 0436, which, per OPSS Addendum A, has a payment rate of \$26.35. This amount multiplied by 60% yields an unadjusted labor-related amount of \$15.81. This amount multiplied by the annual wage index for this facility of 0.8689 yields an adjusted labor-related amount of \$13.74. The non-labor related portion is 40% of the APC rate or \$10.54. The sum of the labor and non-labor related amounts is \$24.28. The cost of these services does not exceed the annual fixed-dollar threshold of \$2,025. The outlier payment amount is \$0. The total Medicare facility specific reimbursement amount for this line is \$24.28. This amount multiplied by 200% yields a MAR of \$48.56.
- Procedure code 96372, date of service December 8, 2011, has a status indicator of S, which denotes a significant procedure, not subject to multiple-procedure discounting, paid under OPSS with separate APC payment. These services are classified under APC 0436, which, per OPSS Addendum A, has a payment rate of \$26.35. This amount multiplied by 60% yields an unadjusted labor-related amount of \$15.81. This amount multiplied by the annual wage index for this facility of 0.8689 yields an adjusted labor-related amount of \$13.74. The non-labor related portion is 40% of the APC rate or \$10.54. The sum of the labor and non-labor related amounts is \$24.28. The cost of these services does not exceed the annual fixed-dollar threshold of \$2,025. The outlier payment amount is \$0. The total Medicare facility specific reimbursement amount for this line is \$24.28. This amount multiplied by 200% yields a MAR of \$48.56.
- Procedure code 93971 has a status indicator of S, which denotes a significant procedure, not subject to multiple-procedure discounting, paid under OPSS with separate APC payment. These services are classified under APC 0266, which, per OPSS Addendum A, has a payment rate of \$96.28. This amount multiplied by 60% yields an unadjusted labor-related amount of \$57.77. This amount multiplied by the annual wage index for this facility of 0.8689 yields an adjusted labor-related amount of \$50.20. The non-labor related portion is 40% of the APC rate or \$38.51. The sum of the labor and non-labor related amounts is \$88.71. The cost of these services does not exceed the annual fixed-dollar threshold of \$2,025. The outlier payment amount is \$0. The total Medicare facility specific reimbursement amount for this line is \$88.71. This amount multiplied by 200% yields a MAR of \$177.42.
- Procedure codes 72157, and 72158, date of service December 6, 2011, have a status indicator of Q3, which denotes conditionally packaged codes that may be paid through a composite APC. A service that is assigned to a composite APC is a major component of a single episode of care. The hospital receives one payment through a composite APC for multiple major separately identifiable services. Payment for any combination of designated procedures performed on the same date is packaged into a single payment. These services are assigned to composite APC 8008, for magnetic resonance imaging (MRI) services including contrast. If a "without contrast" MRI procedure is performed on the same date of service as a "with contrast" MRI, APC 8008 is assigned rather than APC 8007. If a claim includes a composite payment that pays for more than one otherwise separately paid service, the charges for all services included in the composite are summed up to one line. To determine outlier payments, a single cost for the composite APC is estimated from the summarized charges. Total packaged cost is allocated to the composite line-item in proportion to other separately paid services on the claim. This line is assigned status indicator S, which denotes a significant procedure, not subject to multiple-procedure discounting, paid under OPSS with separate APC payment. These services are classified under APC 8008, which, per OPSS Addendum A, has a payment rate of \$994.87. This amount multiplied by 60% yields an unadjusted labor-related amount of \$596.92. This amount multiplied by the annual wage index for this facility of 0.8689 yields an adjusted labor-related amount of \$518.66. The non-labor related portion is 40% of the APC rate or \$397.95. The sum of the labor and non-labor related amounts is \$916.61. Per 42 Code of Federal Regulations §419.43(d) and Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, if the total cost for a service exceeds 1.75 times the OPSS payment and also exceeds the annual fixed-dollar threshold of \$2,025, the outlier payment is 50% of the amount by which the cost exceeds 1.75 times the OPSS payment. Per the OPSS Facility-Specific Impacts file, CMS lists the cost-to-charge ratio for this provider as 0.129. This ratio multiplied by the billed charge of \$10,488.50 yields a cost of \$1,353.02. The total cost of all packaged items is allocated proportionately across all separately paid OPSS services based on the percentage of the total APC payment. The APC payment for these services of \$916.61 divided by the sum of all APC payments is 62.81%. The sum of all packaged costs is \$3,068.07. The allocated portion of packaged costs is \$1,926.92. This amount added to the service cost yields a total cost of \$3,279.94. The cost of these services exceeds the annual fixed-dollar threshold of \$2,025. The amount by which the cost exceeds 1.75 times the OPSS payment is \$1,675.87. 50% of this amount is \$837.94. The total Medicare facility specific reimbursement amount for this line, including outlier payment, is \$1,754.55. This amount multiplied by 200% yields a MAR of \$3,509.09.

5. The total allowable reimbursement for the services in dispute is \$4,916.06. This amount less the amount previously paid by the insurance carrier of \$0.00 leaves an amount due to the requestor of \$4,916.06. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$4,916.06.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$4,916.06, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

_____	_____	September 23, 2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, 37 *Texas Register* 3833, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.